

NHS FORTH VALLEY

**Integrated Care Pathway
For
Bipolar Disorder**

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| This document can, on request, be made available in alternative formats

Consultation and Change Record

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NHS FV Bipolar Integrated Care Pathway

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1. Introduction

This document provides guidelines to the care and treatment of service users with a diagnosis of Bipolar Disorder through the means of an integrated care pathway (ICP).

The document has been produced in accordance with the [NHS Forth Valley Policy on Developing Guidance](#).¹ and applies to Primary Care, Adult Mental Health (AMH), Older Peoples Services (OPS) and the Learning Disabilities Care Groups (LDS).

The term of service user will be used throughout the document to represent those referred to and receiving care and treatment from a range of inpatient and community mental health services.

These ICP guidelines will be used in conjunction with the Generic ICP guidelines according to each Care Group. (AMH, OPS, LDS.)

These can be found in the Mental Health section of the Quality Improvement web pages of the Forth Valley intranet site.

<http://www.nhsforthvalley.com/CE/Index.asp>

Then select "Mental Health" from the guideline drop down list on the right hand side of the screen.

Please note: The [blue highlighted text](#) within the document provides access to web-linked appropriate documentation when read online.

Please press control and click on your computer to follow the link if required.

This ICP has been developed in line with [the NHS Quality Improvement Scotland Standards for Integrated care pathways in mental health bipolar disorder care standards](#).²

The guidelines for this local ICP are underpinned by:

- [the Scottish Intercollegiate Guidelines Network \(SIGN\) 82 – Bipolar Affective Disorder](#)³
- [the National Institute for Health and Clinical Excellence \(NICE\) Bipolar Disorder Guideline 38](#).⁴
- [British Association of Psychopharmacology guidelines - Bipolar Disorder](#)⁵
- [Maudsley Prescribing Guidelines in Psychiatry 10th ed.](#)⁶

This ICP contains recommendations based on the best available clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (product licence).

Where a medicine is prescribed outwith the product licence, the prescriber needs to be aware that they are responsible for this decision and must document the clinical need.

¹ NHS Forth Valley Policy on Developing Guidance (April2010).

² <http://icptoolkit.org/>

³ <http://www.sign.ac.uk/guidelines/fulltext/82/index.html>

⁴ <http://guidance.nice.org.uk/CG38>

⁵ http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf

⁶ <http://www.informahealthcarebooks.com/bestsellers/maudsley.html>

Where classes of medicines are recommended, e.g. atypical antipsychotics, prescribers must acquaint themselves with which medicines are licensed and have Scottish Medicines Consortium (SMC) approval for the prescribed indication .

See links to:

The electronic Medicines Compendium (eMC) contains information about UK licensed medicines.
<http://www.medicines.org.uk/EMC/default.aspx>

Scottish Medicines Consortium (SMC): <http://www.scottishmedicines.org.uk/Home>

NHS Forth Valley procedures should be followed for the prescribing of unlicensed and non-SMC approved medicines.

See link:

http://intranet.fv.scot.nhs.uk/web/FILES/Pharmacyfiles/NHSFVIPTRpolicywithappendicesv1_3final.pdf

2. Standard Documentation

The Bipolar ICP documentation will be used in conjunction with the documentation used for the Generic ICP for those with a diagnosis of bipolar disorder.

2.1 Assessment Tools

Within the Bipolar Disorder ICP standards the following criteria are listed:

Standard 22: Treatment and outcomes are recorded for the acute mania phase.

22b The care record shows a measurement of outcome in acute mania using a validated tool, e.g. Young Mania Rating Scale (YMRS).

Standard 23: There is a record of screening for and management of bipolar depression.

23c The care record shows the use of a professionally rated assessment tool to monitor outcome, e.g. Montgomery Asberg Depression Rating Scale (MADRS).

The Bipolar ICP Development group examined a range of tools and the following are recommended for use in the appropriate care group setting.

(Please see appendix I for a description of these.)

Assessment Tools		
Adult Mental Health	Older Peoples Services	Learning Disabilities
YMRS	Cornell	GDS for People with LD
MADRS	GDS-30	GDS-CS (Carer)
CGI-Bipolar	YMRS	Mini-PASSAD
ISS		
BPDRS		

These assessment tools will be available and should be completed on the FACE system. PDF formats will be available for reference only on [Mental Health Initiatives documentation web page](#).

(Assessment tools still to be added.)

3. What is an Integrated Care Pathway (ICP)?

- It is an explicit agreement by a local group of staff and workers, both multi-disciplinary and multi-agency, to provide a comprehensive service to a clinical or care group on the basis of current views of good practice and any available evidence or guideline.
- It is important that the group agree on communication, record keeping and audit.
- There should be a mechanism to pick up when a patient has not received any care input specified by the pathway so that the omission can be remedied.
- The local group should be committed to continuous improvement of the integrated care pathway on the basis of new evidence, of service developments or of problems in implementation.

(Definition extracted from Standards for Integrated care pathways for mental health)

4. Whole System and Recovery Approach

Mental health services provide support, assistance and treatment for those with a mental illness and support to their informal carers. Mental illness is a general term for a wide range of disorders where mental functioning such as perception, memory, emotion or thought is affected. Care is provided by a range of services within NHS primary care, NHS secondary care, Local Authority, Voluntary Organisations and the Independent Sector.

This ICP was developed using a whole systems approach by ensuring the involvement and consultation of a wide range of services, organisations and individuals who would be affected by the delivery of; or be in receipt of care by way of this ICP.

This ICP includes stakeholder input from service users, carers, and members of staff from the healthcare, local authority, voluntary and independent sector organisations within the Forth Valley area.

ICPs must capture the ethos and values of recovery and deliver recovery-orientated services. The Scottish Recovery Network describes recovery as:

“Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.”

For further information on recovery and mental health please click link below.

<http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html>⁷

⁷ <http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html>

5. Bipolar Disorder

Bipolar Disorder is described in terms of diagnostic criteria and presenting clinical symptoms and this can be found in the:

- [World Health Organisations ICD -10 classification of Mental and Behavioural Disorders.](#)⁸
- [American Psychiatry Associations Diagnostic and Statistical Manual- DSM IV.](#)⁹
- [Diagnostic Criteria for psychiatric disorders for use with adults with learning disabilities/mental retardation](#)¹⁰

Most people experience ups and downs in their mood but in Bipolar Disorder these can become so extreme that they interfere with everyday activities of living, feelings, perception and behaviour. Episodes of mood can last for months at a time.

Bipolar disorder often first occurs when work, study, family, health or emotional pressures or stressors are at their greatest. In women it can also be triggered by childbirth or the menopause. Both men and women of any age from adolescence onward and from any social or ethnic background can develop bipolar disorder¹¹.

The symptoms experienced during an episode of mania may include:

- Incoherent , rapid or disjointed thinking
- Talkativeness
- Severely impaired judgement
- Rapidly occurring and changing plans and ideas
- Constant elation and /or euphoria
- Inappropriate optimism
- Grandiose delusions and ideas
- Gross over-estimation of personal capability
- Waking early and highly energised
- Need for little sleep (less than 5 hours)
- Promiscuous /increased sexual behaviour
- Altered perception and psychosis

The symptoms experienced during an episode of depression may include:

- Feelings of emptiness and worthlessness
- Loss of energy and motivation for many or all of everyday activities including self care
- Pessimism or negativity
- Loss of concentration
- Loss of appetite
- Self doubt and self blame
- Isolation from friends and family
- Poor quality of sleep , with early morning waking
- Inability to get out of bed until late morning or early afternoon
- Thoughts of death or suicide

⁸ <http://apps.who.int/classifications/apps/icd/icd10online/>

⁹ <http://www.psych.org/MainMenu/Research/DSMIV/DSMIVTR.aspx>

¹⁰ <http://onlinelibrary.wiley.com/doi/10.1046/j.1365->

[2788.47.s1.2.x/abstract;jsessionid=3D942913B88A7B29D3C9D24E21F14A59.d01:t02](http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2788.47.s1.2.x/abstract;jsessionid=3D942913B88A7B29D3C9D24E21F14A59.d01:t02)

¹¹ www.bipolarscotland.org.uk

During both manic and depressive episodes there can be the presence or absence of psychotic symptoms including delusions, hallucinations and altered perception and impaired cognition.

Typically the best outcome for the person coping with Bipolar Disorder will be achieved by early diagnosis by qualified mental health specialists and acceptance of the condition. Severe and/or untreated episodes of Bipolar Disorder can be very damaging to the person affected, their families and carers.

Generic specialist assessment will be conducted through the means of the Generic ICP to support obtaining a diagnosis.

5.1 Bipolar Disorder in Learning Disability

Mania is best recognised by comparing the person's normal behaviour with that which they exhibit during a period of instability.

Presentation may be similar to the general population in those that have a mild learning disability, but is more difficult to assess, the more severe the learning disability. It is thought that age of presentation is usually earlier than the general population.

In addition to symptoms experienced by the general population the following symptoms and signs that suggest mania include:

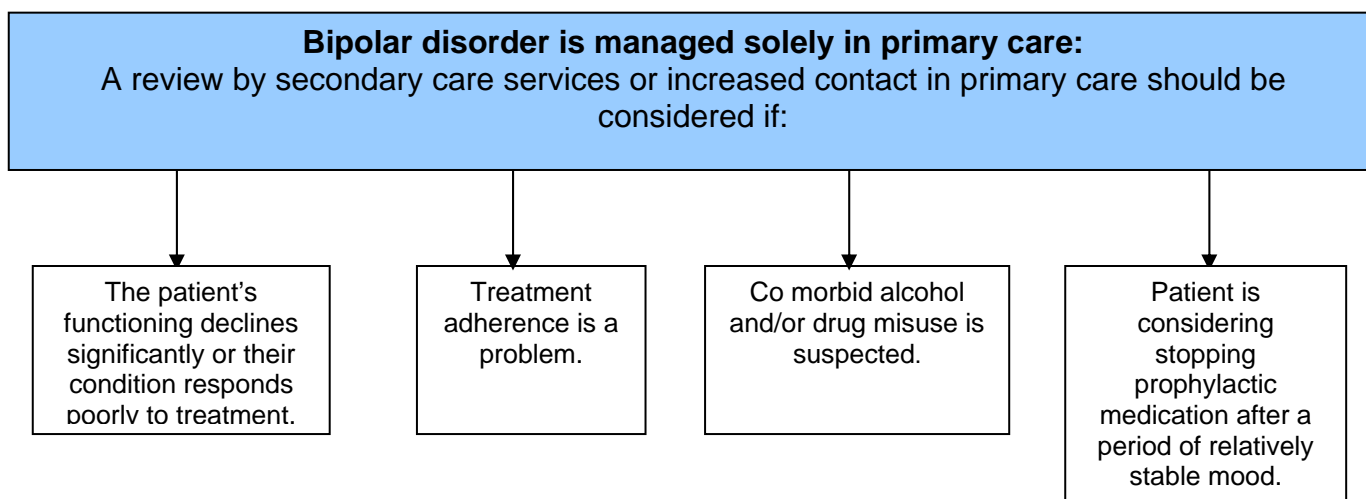
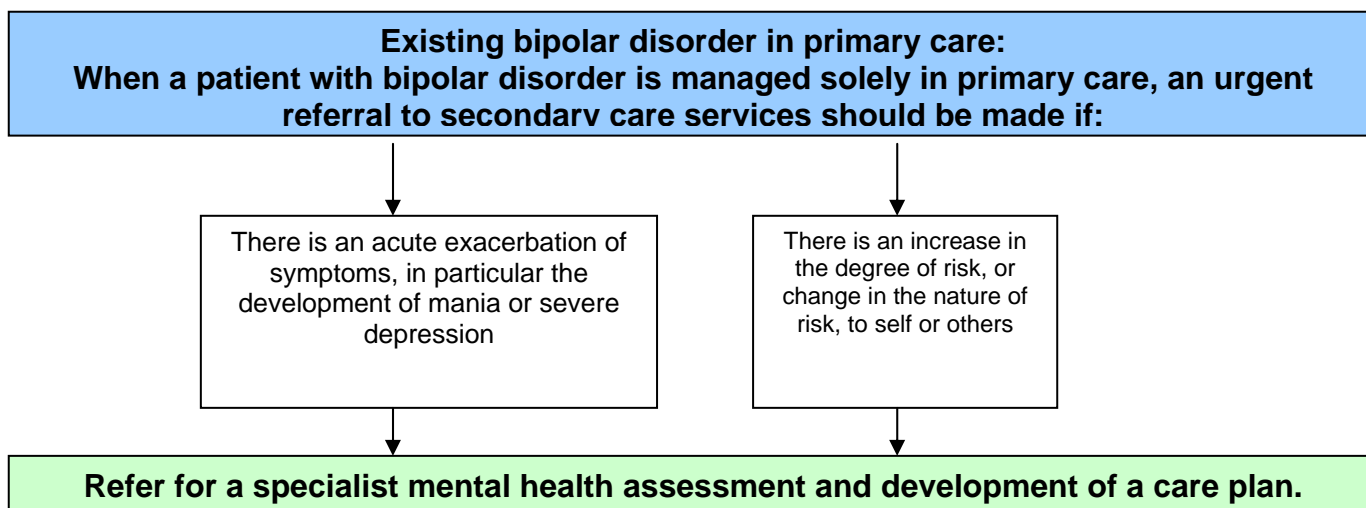
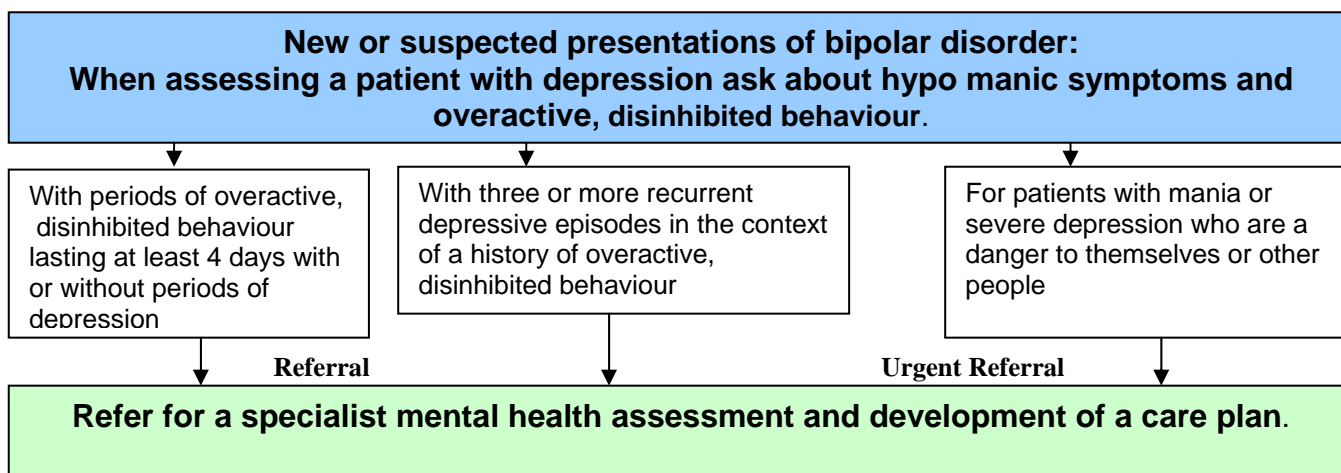
- Over activity
- Impulsivity
- Aggression/Destructive behaviour
- Irritability(there is often no elevation in mood)
- Self harm
- Intrusiveness
- Confusion
- Cognitive impairment

In addition to symptoms experienced by the general population, the following symptoms and signs that suggest depression include:

- Aggression
- Irritability
- Somatic/hypochondriacal symptoms
- Agitation/Unexplained temper tantrums
- Wandering
- Mutism
- Altered self care
- Incontinence

6. Primary screening for Bipolar Disorder/Referral to Secondary care

“Bipolar patients may present with depression. Ask about a history of elated, excited or irritable mood of any duration in all patients with depression and about a family history of mania. Anxiety disorders are highly co-morbid with bipolar disorder from a lifetime perspective, and anxiety symptoms are associated with increased illness burden and poor outcome: both require assessment and treatment.” (BAP 2009)



7. Specialist Assessment and Diagnosis

Generic guidelines for assessment will be followed in accordance with the Generic ICP.

Bipolar disorder is a disorder of mood and is characterised by repeated, that is, at least two episodes in which a person's mood and activity levels are significantly disturbed. Mood episodes can be characterised as:

- Depressed, during which low mood is associated with decreased energy and activity.
- Elated (mania or hypomania) during which elevation of mood is associated with increased energy and activity.
- Mixed affective state, during which symptoms of both depression and elation of mood occur together.¹²¹³¹⁴

“Individuals with bipolar disorder may initially present with depression or have repeated episodes of depression. It is important to ask about a history of elated, excited or irritable mood of any duration in all patients with depression and about a family history of mania. Anxiety disorders are highly co-morbid with bipolar disorder from a lifetime perspective, and anxiety symptoms are associated with increased illness burden and poor outcome therefore both require assessment and treatment.” (BAP 2009)

Repeated episodes of mania are comparatively rare however about one in every hundred adults will experience bipolar disorder in their lifetime. Both men and woman are equally affected. The disorder usually presents during or after the teenage years and though unusual after forty years, can present at any age.

Following diagnosis of bipolar disorder, ongoing multidisciplinary assessment is required including obtaining carer's views to produce a holistic plan of care. This should include consideration of the physical, psychological and social impact of the illness during periods of elation and depression. During episodes of elation, care is required in assessing and managing the consequences of behavioural disinhibition.

During such spells the effects of this disinhibition can have effects upon all relationships including those in the family and have a disruptive effect upon social and occupational function. In addition, ability to manage financial affairs can be much disrupted. During severe elation neglect of self-care and nutrition can lead to eventual physical exhaustion.

During depressed episodes assessment and management includes assessment of social withdrawal and impairment of self-care. Vigilance is also needed for assessment of risk of self-injury and of suicidal behaviour.

¹² <http://www.sign.ac.uk/pdf/sign82.pdf#page=8>

¹³ http://eng.mapofmedicine.com/evidence/map/bipolar_disorder1.html

¹⁴ http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf#page=3

People suffering from bipolar affective disorder are particularly at risk of co-morbid alcohol and substance misuse difficulties and therefore this should be addressed at assessment and in care planning.

Where substance misuse is present refer to Generic ICP guideline on the treatment of substance misuse for service users with mental illness and where appropriate apply the:

[Forth Valley Shared Care Protocol](#).¹⁵

Special consideration should be given to women of child bearing age and any dependants. This should address care planning around contraception and conception as well as careful monitoring of mood in the post partum period when the risk of relapse is particularly high.

8. Assessment of Risk and Risk Management

Generic guidelines for risk assessment will be followed in accordance with the Generic ICP.

A risk assessment will be undertaken when:

- | |
|--|
| • bipolar disorder is first diagnosed. |
| • a person with bipolar disorder undergoes significant change in mental state or personal circumstances. |
| • a person with bipolar disorder is discharged from or is on leave from inpatient care or transferred from one service to another. |

The following risks will be considered when developing a crisis and risk management plans with the service user:

- | |
|--|
| • The adjustment period following diagnosis of bipolar disorder. |
| • Suicide. |
| • Exploitation or severe self-neglect. |
| • Significant risk to others (including neglect of dependents). |
| • A history of recurrent admissions, particularly compulsory admissions. |

¹⁵ http://www.nhsforthvalley.com/QI/CE_Guidance.asp?topic=Mental%20Health

The management plan will include:

- | |
|--|
| <ul style="list-style-type: none">• potential personal, social or environmental triggers and early warning symptoms of relapse. |
| <ul style="list-style-type: none">• a protocol for increasing the dose of medication or taking additional medication (which may be given to the patient in advance) for patients who are at risk of rapid onset of mania and for whom clear early warning signs can be identified – protocols should be monitored regularly, and are not a substitute for an urgent review . |

8.1 Care Programme Approach (CPA)

The CPA enables a multi-disciplinary and multi agency approach to working in partnership with a service user with complex social care needs and severe and complex mental health problems to manage their own lifestyle.

This involves assessment care planning, care provision, review and discharge processes at a multi-agency level and will include the involvement of family and carers where appropriate. CPA meetings and documentation helps ensure that there is regular communication between everyone involved.

A care coordinator is appointed from the multi-disciplinary team to co-ordinate the delivery of care as identified in the service user's care plan. The coordinator does not have the sole responsibility for delivering the overall care package but will provide some direct input as identified in the care plan.

Criteria for referral to CPA

(Guidelines for CPA will be followed according to locally agreed protocols in the local authority areas of Falkirk, Stirling and Clackmannanshire.)

Whether CPA support is needed depends on whether the service user:

- | |
|--|
| <ul style="list-style-type: none">• is diagnosed as having a severe mental disorder. |
| <ul style="list-style-type: none">• is at risk of suicide, self-harm or harm to others. |
| <ul style="list-style-type: none">• tends to neglect themselves and does not take treatment regularly. |
| <ul style="list-style-type: none">• is vulnerable for various reasons, such as physical or emotional abuse, or has financial difficulties due to their mental illness or cognitive impairment. |
| <ul style="list-style-type: none">• has misused drugs or alcohol. |
| <ul style="list-style-type: none">• relies significantly on the support of a carer, or has their own caring responsibilities. |
| <ul style="list-style-type: none">• has recently been detained under the Mental Health Act. |
| <ul style="list-style-type: none">• (A small number of service users may require an Enhanced CPA.) |

9. Post Diagnostic Support

- | |
|---|
| <ul style="list-style-type: none">• Written and verbal information on Bipolar Disorder and its management, including how families and carers can obtain help through all phases of the illness will be offered to service users and their families/carers.
Please see resource list – appendix 2 |
| <ul style="list-style-type: none">• This will include access to and availability of local illness specific support groups for individuals and their carers within the Forth Valley area. These groups will incorporate a standardised group programme approach. |
| <ul style="list-style-type: none">• Confidentiality must be negotiated with the patient before information is shared with families and their carers |

10. Acute Mania

Assessment should include identifying :

- severity and the use of a validated tool to aid clinical judgement.
- co-morbidity especially with substance misuse.
- physical illnesses such as Diabetes Mellitus ,Ischaemic Heart Disease, Stroke and Acute Infection. Screening for Delirium.
- childbearing age/age appropriate options
- suicide risk, an advance statement and the appropriate setting for care and treatment.(likely inpatient setting or IHTT).
- patient/family preferences.
- the possible need of use of the Adults with Incapacity Act and /or Mental Health Act.

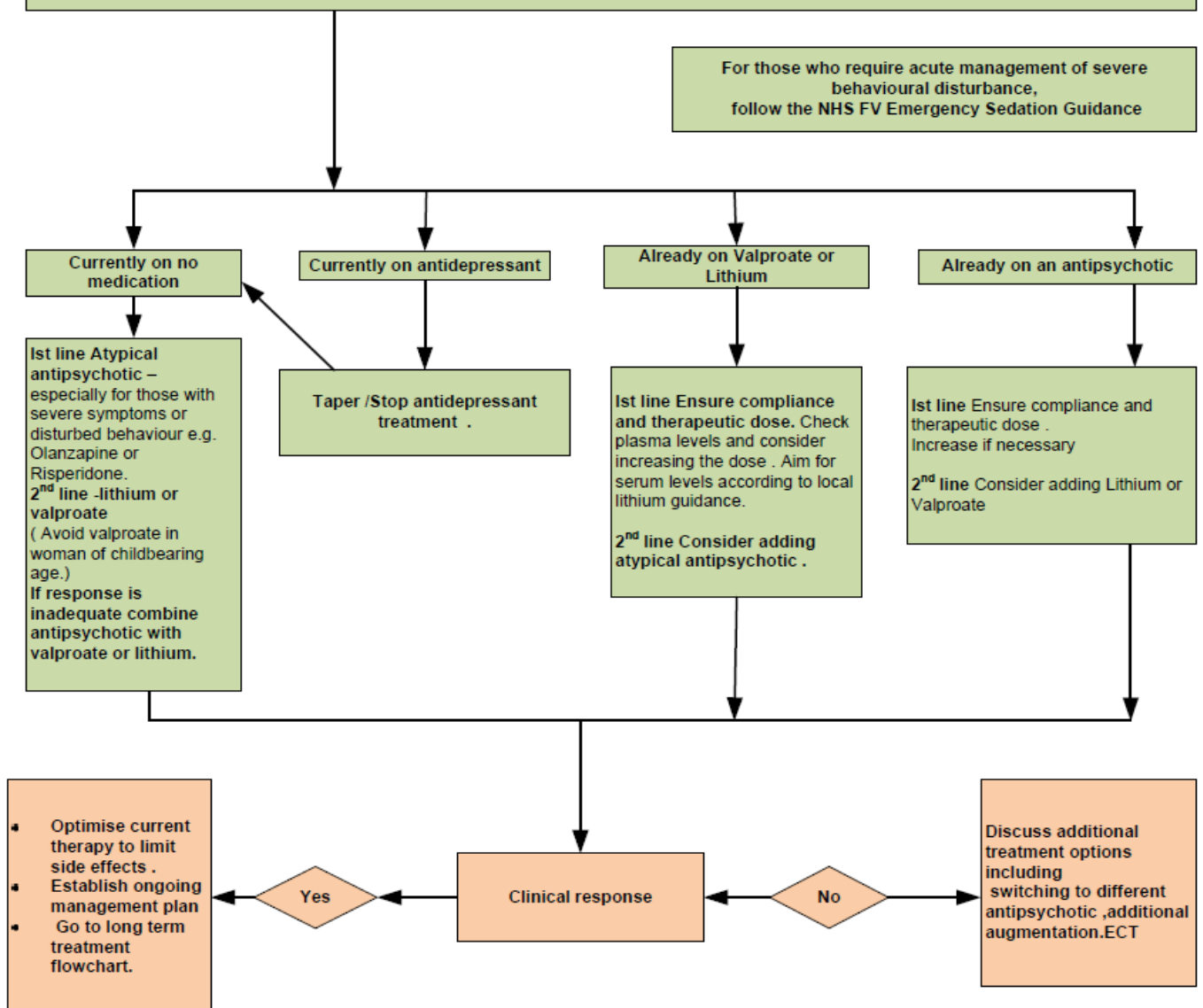
Treatment options should consider the :

- need for future prophylactic use ,
- likelihood of compliance/concordance,
- potential adverse effects
- the risks for physical health and risk of pregnancy.
- patient preferences
- previous interventions tried.

Ensure that patient/carer involvement and communication with other appropriate services occurs.

For all patients consider adding short term benzodiazepine particularly if sleep deprived

For those who require acute management of severe behavioural disturbance, follow the NHS FV Emergency Sedation Guidance



Please note :

- If treating a pregnant /breast feeding woman ; seek specialist advice regarding prescribing.
- Avoid antidepressant prescribing if recent hypomania ,rapid cycling bipolar affective disorder or recent functional impairment caused by rapid mood fluctuations.
- The use of carbamazepine , gabapentin, lamotrigine and topiramate are not recommended for the treatment of acute mania .
- Valproic acid (as the semisodium salt) is licensed for the treatment of manic episodes; sodium valproate is not licensed for this indication.

10.1 The management of acute mania symptoms

Key features in both mania and hypomania are evident in varying degrees. These include elevated, expansive or irritable mood, psychotic symptoms may or may not be evident, increased energy, activity and restlessness, racing thoughts, easily distracted, sleep disturbance, unrealistic beliefs regarding abilities, poor judgement and overall impairment in functioning.

10.2 Assessment

- **Exclusion of any organic causes and alcohol /drug related states** needs to be considered.
- **Clinical judgment and the use of a validated tool, where possible, at initial assessment** are required to help determine the treatment plan. This tool can be used again during the episode of care as an outcome measure. **(See appendix for recommended tools).**

(QIS Bipolar Disorder ICP Care Standard 22: Treatment and outcomes are recorded for the acute mania phase.)

- Risk assessment should be repeated when a person with bipolar disorder undergoes significant change in mental state or personal circumstances or when transferred from one care setting to another e.g. admission to and discharge from hospital. (NICE 12.31).

10.3 Treatment

For all patients, consideration should be given to using short term benzodiazepines especially if sleep deprived.

Guidelines are available for use by clinical staff in in-patient care settings when managing acutely disturbed patients who may require emergency sedation when non-pharmacological interventions have failed or been refused.

The aim of emergency sedation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others. It is not to induce sleep or unconsciousness.

Link to NHS Forth Valley Emergency Sedation Guidelines.

http://intranet.fv.scot.nhs.uk/web/FILES/Pharmacyfiles/FINAL_emerg_sed_29_June_v3%5B1%5D.10_complete.pdf

- **Antidepressants should be stopped at onset of acute manic phase** however a decision should be considered on how discontinuation is managed and whether it is abrupt or gradual. Consideration should be given to:

• current clinical need.
• previous experience of discontinuation/withdrawal symptoms.
• risks of discontinuation /withdrawal symptoms.

- **First line use of licensed atypical antipsychotic medication should be considered when manic symptoms are severe** or there is a marked behavioural disturbance, for example olanzapine, or risperidone.

- **Second line treatment of valproate or lithium should be considered** especially if there has been a good response in the past or compliance with above medication is good. Note valproic acid (as the semisodium salt) is licensed for the treatment of manic episodes; sodium valproate is not licensed for this indication.
- If using lithium ensure the provision and discussion of the NPSA Lithium therapy booklet/alert card/record card . [Link to Lithium Guideline](#).¹⁶
- **The use of carbamazepine , gabapentin, lamotrigine and topiramate are not recommended for the treatment of acute mania,**
- **All patients on medications will be reviewed** in conjunction with monitoring the clinical presentation **on an ongoing basis.**
- **Review presentation within a week of the first episode and continue to review regularly within a minimum of a two to four week period in the first 3 months** then less frequent if response is good (NICE Guidelines). Plans for review should be according to the needs of the individual and the agreed clinical management plan
- **It is important to discuss contraception and risk of pregnancy with women of childbearing age and encourage women to discuss pregnancy plans with their doctor.**

Please see link: [NICE guidelines on Antenatal and Postnatal Mental Health](#)¹⁷

and [Forth Valley Perinatal Mental Health](#)¹⁸

The UK Teratology Information Service (UKTIS), is commissioned by the Health Protection Agency to provide an enquiry answering service (0844 892 0909) on all aspects of the toxicity of drugs and chemicals during pregnancy to healthcare professionals. UKTIS produce summaries of drug and chemical safety in pregnancy.

- **Valproate should be avoided in women of childbearing age. (NICE)**

¹⁶

http://intranet.fv.scot.nhs.uk/web/FILES/Pharmacyfiles/Lithium_guideline_2010_version_1_final%5B1%5D.pdf

¹⁷ <http://www.nice.org.uk/CG45>

¹⁸ http://www.nhsforthvalley.com/CE/CE_Guidance.asp?topic=Peri%20Natal%20Mental%20Health

11. Bipolar Depression

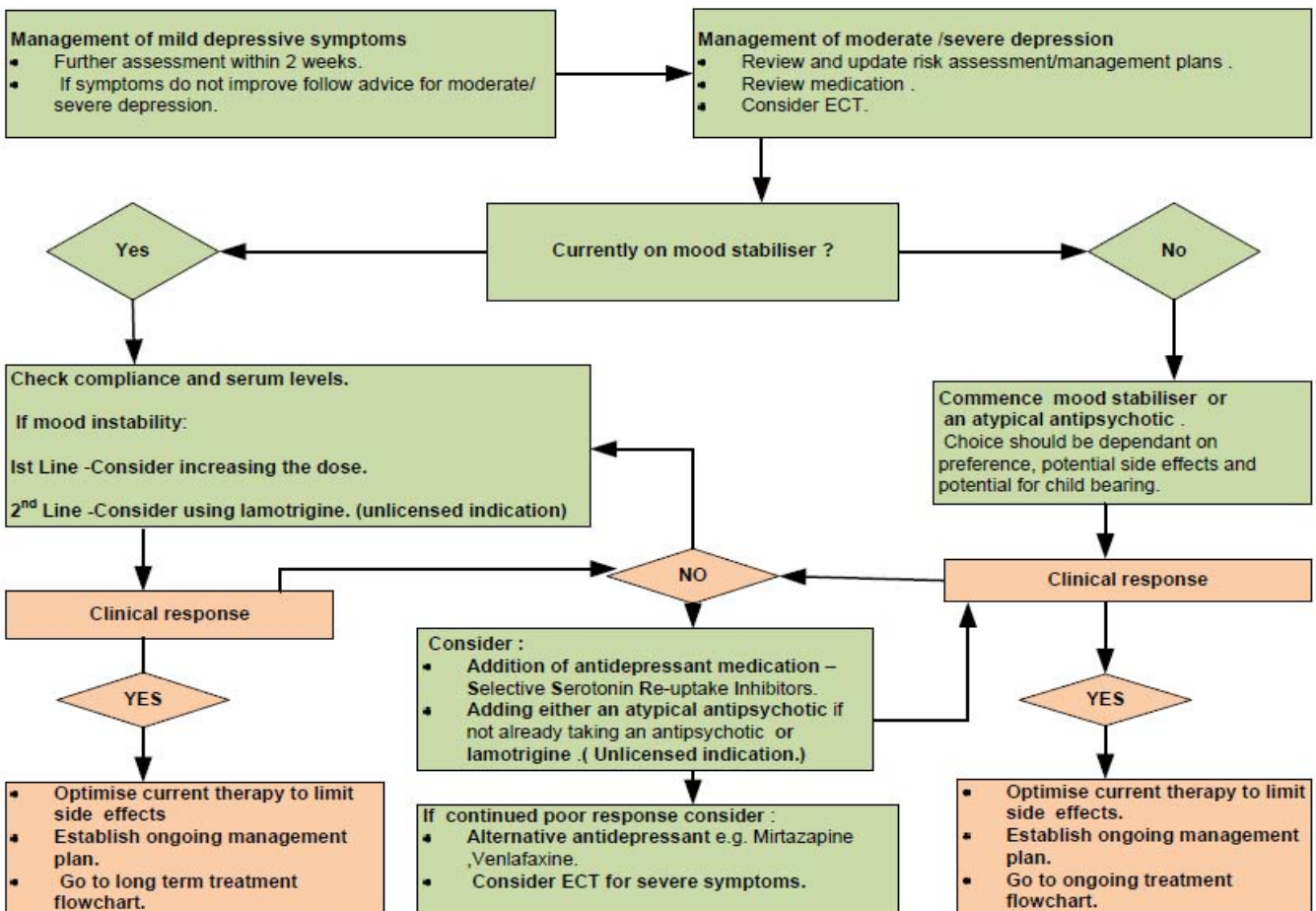
Assessment should include identifying :

- severity of depression(mild/moderate/severe) and the use of a validated tool to aid clinical judgement,
- co-morbidity substance misuse.
- physical illnesses such as Diabetes Mellitus, Ischaemic Heart Disease, Stroke and Acute Infection,
- childbearing age/age appropriate options,
- suicide risk, evidence of an advance statement and the appropriate setting for care and treatment,
- the possible need for use of Adults with Incapacity Act /Mental Health Act.

Treatment options should consider the :

- previous interventions tried,
- need for future prophylactic use,
- likelihood for compliance /concordance,
- potential adverse effects,
- risks for physical health and risk of pregnancy.
- patient/carer preferences

Ensure patient/carer involvement and communication with other appropriate services occurs.



Please note :

- If treating a pregnant /breast feeding woman ; seek specialist advice regarding prescribing.
- Avoid antidepressant prescribing if recent hypomania ,rapid cycling bipolar affective disorder or recent functional impairment caused by rapid mood fluctuations.
- When prescribing an antidepressant in the absence of an anti manic medication ensure that an explanation is given to the individual of the risk of developing mania and the benefits of adding anti manic medication.
- If unwilling to take anti manic medication – monitor mood carefully.
- Lamotrigine is unlicensed for active treatment of depressive episodes.
- Valproate is not licensed for the treatment of bipolar depression.

Additional interventions should be considered regarding:

- Activity scheduling.
- Appropriate diet/sleep/exercise.
- Social support /networks.
- Increased formal monitoring and support.
- Evidenced- based psychological interventions.

If depressive symptoms have improved :

- Note that maintenance antidepressants are of limited benefit.
- Consider tapering and then stopping antidepressant medication 8 weeks after symptom response to minimise risk of mania.
- If withdrawing antidepressants do so slowly and gradually with particular care with paroxetine / venlafaxine.
- Continue mood stabiliser to prevent relapse.

11.1 The management of acute depressive symptoms

Managing acute depressive symptoms in bipolar disorder has some similarities to managing unipolar depression. However, in bipolar disorder, antidepressants may be involved in cycle acceleration (mood destabilisation). There is only a limited role for maintenance treatment with antidepressants in bipolar depression; prophylactic medication has a greater role. When prescribing an antidepressant, an antimanic medication should also be prescribed.

Patients with bipolar disorder typically experience more fluctuations in both the severity and duration of symptoms than people with unipolar depression, but there is little evidence on which to base guidance on treating symptoms of different severities. When severity should be taken into account (for example, to avoid unnecessary initiation of medication), the terms 'mild', 'moderate' and 'severe' are used. (NICE 2006)

11.2 Assessment

Clinical judgment and the use of a validated tool, where possible, at initial assessment are required to help determine the treatment plan. This tool can be used again during the episode of care as an outcome measure. **(See appendix for recommended tools.)**

(QIS Bipolar Disorder ICP Standard 23. There is a record of screening for and management of bipolar depression.)

- **Care plans will be devised in collaboration with the person and to include aspects of risk management and self management.**
- **It is important to discuss contraception and risk of pregnancy with women of childbearing age and encourage women to discuss pregnancy plans with their doctor. Please see link: [NICE guidelines on Antenatal and Postnatal Mental Health](#)¹⁹
[Forth Valley Perinatal Mental Health](#)²⁰**

(The UK Teratology Information Service (UKTIS), is commissioned by the Health Protection Agency to provide an enquiry answering service (0844 892 0909) on all aspects of the toxicity of drugs and chemicals during pregnancy to healthcare professionals. UKTIS produce summaries of drug and chemical safety in pregnancy.)

- **Valproate should be avoided in women of childbearing age. (NICE)**
- **Review presentation within a week of the first episode and continue to review regularly within a minimum of a two to four week period in the first 3 months then less frequent if response is good (NICE Guidelines).**
Plans for review should be according to the needs of the individual and the agreed clinical management plan.

¹⁹ <http://www.nice.org.uk/CG45>

²⁰ http://www.nhsforthvalley.com/CE/CE_Guidance.asp?topic=Peri%20Natal%20Mental%20Health

11.3 Management of people with mild depressive symptoms:

- **Arrange a further assessment, normally within 2 weeks** if the person's previous episodes of mild depression have not developed into chronic or more severe depression, or a more severe depression is not likely.
- **If symptoms do not improve follow the advice for moderate or severe depression.**

11.4 Management of people with moderate or severe depressive symptoms:

Risk assessment should be repeated when a person with bipolar disorder undergoes significant change in mental state or personal circumstances or when transferred from one care setting to another e.g. admission to and discharge from hospital. (NICE 12.31).

- Risk management plans should be updated accordingly. (Nice 12.41.)

With regard to medication options, this differs from unipolar depression in that first consideration would be commencement of a mood stabiliser before use of antidepressant medication. Note valproate is not licensed for the treatment of bipolar depression. If the use of a mood stabiliser is refused by the patient, then careful monitoring of mental state is required.

- **If there is no significant improvement after an adequate trial of medication, consider a structured psychological therapy** focused on depressive symptoms, problem solving, improving social functioning and medication concordance.
- **Consider the use of Electroconvulsive Therapy.** ([Link to local guidance /protocol to be added.](#))

Please see link below to Scottish ECT Accreditation Network.

This site is designed to complement the work of SEAN enabling communication of the latest information on ECT (Electroconvulsive Therapy) in Scotland.

<http://www.sean.org.uk/>

11.5 Antidepressant treatment and risk monitoring:

- Give information regarding treatment with antidepressants and address the person's concerns about taking antidepressants, for example regarding developing a craving or tolerance.
- Antidepressant treatment, for example SSRI, should begin at a low dose and increased gradually where necessary. Refer to NHS Forth Valley Formulary.
See link:
http://intranet.fv.scot.nhs.uk/web/FILES/Pharmacyfiles/FV_Formulary_2011_FinalA5.pdf
- Avoid antidepressants for people who have rapid-cycling bipolar disorder, a recent hypomanic episode or recent functionally impairing rapid mood fluctuations. Instead, consider increasing the dose of the antimanic medication or adding a second one and recommendations for women of childbearing age /pregnancy.

11.6 Following remission of depressive symptoms consider:

- Tapering antidepressants after 8 weeks of maintenance treatment, provided there is no relapse of depressive symptoms.
- Continuing mood stabiliser to prevent relapse
- **Review presentation within a week of the first episode and continue to review regularly within a minimum of a two to four week period in the first 3 months** then less frequent if response is good (NICE Guidelines).
Plans for review should be according to the needs of the individual and the agreed clinical management plan.

- Guidance on long-term treatment of bipolar disorder is available in SIGN (2005), NICE (2006), BAP (2009) and the Maudsley Guidelines (2009).
- The primary long-term treatments are pharmacological, but psychological and psychosocial interventions have an important part to play
- A co-ordinated care programme, with rapid access to support at times of crisis, is essential (NICE, 2006).
- Before embarking on maintenance treatment, patient and doctor should consider the severity of the last episode, number, frequency and severity of previous episodes, and personal factors .

Criteria for starting long-term medication (See Section 12.1.)

A mood-stabiliser should be prescribed as prophylaxis:

- After a single manic episode that was associated with significant risk and adverse consequences or
- In the case of bipolar I illness, after two or more acute episodes or
- In the case of bipolar II illness, if there is significant functional impairment, frequent episodes or significant risk of suicide.

Choice of Medication (See Section 12.2)

NICE (2006) recommends that the choice of medication should depend on:

- response to previous treatments.
- the risk, and known precipitants, of manic versus depressive relapse.
- physical risk factors, particularly renal disease, obesity and diabetes.
- the patient's preference and history of adherence.
- gender (valproate should not be prescribed for women of child-bearing potential).
- a brief assessment of cognitive state, if appropriate.

The reasons for the choice and the discussion with the patient of the potential benefit and risks should be documented (NICE, 2006).

Combinations of Drug Treatments (See Section 12.3)

Many service users experience sub-threshold symptoms or relapses on a single mood-stabiliser, so combinations of mood-stabilisers or a mood-stabiliser and an antipsychotic are commonly used (Maudsley, 2009; BAP, 2009).

- The prevention of relapse may often require complex treatment strategies (SIGN, 2005). There is some evidence that continuing combinations which were effective in mania provides optimal prophylaxis (Maudsley, 2009).
- The risk of side-effects is increased when more than one drug is used. Combinations of two from lithium, olanzapine and valproate are recommended by NICE (2006).

Additional Short Term Medication (See Section 12.4)

The use of additional short-term medication (e.g. benzodiazepines or antipsychotics) is necessary when an acute stressor is imminent or present, early symptoms of relapse (especially insomnia) occur or anxiety becomes prominent.

- Consider supplying short-term medications in advance to patients for use as required, though this option may not be suitable for every patient.
- Give clear advice about why, when and how to take additional short-term medication, and when to seek medical attention (BAP, 2009). Higher doses of the long-term treatments may also be effective if blood levels permit and the dose is below the maximum recommended dose (BAP, 2009).

Duration of Treatment (See Section 12.5)

The various guidelines differ in their recommendations about duration of long-term treatment.

According to NICE (2006), long-term drug treatment should normally continue for at least two years after an episode of bipolar disorder, and up to five years if the person has risk factors for relapse (a history of frequent relapses or severe psychotic episodes, co morbid substance misuse, ongoing stressful life events, or poor social support). This should be discussed with the patient and there should be regular reviews.

BAP (2009) recommends continuing treatment indefinitely.

Please note

- Without active acceptance of the need for long-term treatment, adherence may be poor (BAP, 2009). Consider a wider package of treatment offering enhanced psychological and social support (BAP, 2009).
- Valproate should not be prescribed for women of child-bearing potential.
- Patients should not routinely continue on antidepressant treatment long-term because there is no evidence that this reduces relapse rates.
- Long-acting intramuscular injections of antipsychotics are not recommended for routine use in bipolar disorder.

12. Maintenance Treatment of Bipolar Disorder

Guidance on long-term treatment of bipolar disorder is available in SIGN (2005)²¹, NICE (2006),²² BAP (2009)²³ and the Maudsley Prescribing Guidelines 10th ed. (2009).²⁴

Bipolar disorder is a chronic relapsing and remitting disorder. Long-term treatment and support are required to minimise the risk of recurrence and optimise quality of life, and social and personal functioning (NICE, 2006). The primary long-term treatments are pharmacological, but psychological and psychosocial interventions have an important part to play and are discussed in the next chapter. A co-ordinated care programme, with rapid access to support at times of crisis, is essential (NICE, 2006).

12.1 Criteria for starting long term medication

NICE (2006) recommends that a mood-stabiliser should be prescribed as prophylaxis:

- After a single manic episode that was associated with significant risk and adverse consequences or
- In the case of bipolar I illness, after two or more acute episodes or
- In the case of bipolar II illness, if there is significant functional impairment, frequent episodes or significant risk of suicide.

See link for definitions of above:

- [World Health Organisations ICD -10 classification of Mental and Behavioural Disorders.](#)²⁵
- [American Psychiatry Associations Diagnostic and Statistical Manual- DSM IV.](#)²⁶
- [Diagnostic Criteria for psychiatric disorders for use with adults with learning disabilities/mental retardation](#)

Without active acceptance of the need for long-term treatment, adherence may be poor (BAP, 2009). Consider a wider package of treatment offering enhanced psychological and social support (BAP, 2009).

The patient's views about 'acceptable risk' of recurrence versus 'acceptable side-effect burden' are paramount (Maudsley, 2009). Before embarking on maintenance treatment, patient and doctor should consider the severity of the last episode, number, frequency and severity of previous episodes, and personal factors (such as a wish to become pregnant or the wish to avoid sick leave from work or education) (SIGN, 2005).

12.2 Choice of medication

NICE (2006) recommends that the choice of medication should depend on:

- response to previous treatments
- the risk, and known precipitants, of manic versus depressive relapse
- physical risk factors, particularly renal disease, obesity and diabetes

²¹ <http://www.sign.ac.uk/pdf/sign82.pdf#page=8>

²² <http://www.nice.org.uk/nicemedia/live/10990/30193/30193.pdf#page=13>

²³ http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf#page=3

²⁴ <http://www.informahealthcarebooks.com/bestsellers/maudsley.html>

²⁵ <http://apps.who.int/classifications/apps/icd/icd10online/>

²⁶ <http://www.psych.org/MainMenu/Research/DSMIV/DSMIVTR.aspx>

- the patient's preference and history of adherence
- gender (valproate should not be prescribed for women of child-bearing potential)
- a brief assessment of cognitive state, if appropriate.

The reasons for the choice and the discussion with the patient of the potential benefit and risks should be documented (NICE, 2006).

Most evidence supports the efficacy of lithium (Maudsley, 2009), and it is recommended for initial monotherapy (BAP, 2009). SIGN (2005) states that lithium is the treatment of choice for relapse prevention in bipolar affective illness, and it is one of the three drugs recommended by NICE (2006) as first-line prophylactic agents (the others being olanzapine and valproate).

Lithium has the advantage of an accepted anti-suicidal effect, though the disadvantage of a worsened outcome if stopped abruptly (Maudsley, 2009). It is probably effective against both depressive and manic relapse, especially the latter. Higher lithium blood levels (>0.7 mmol/l) are more effective than lower levels (SIGN, 2005), and levels less than 0.5 mmol/l are usually too low (BAP, 2009). The highest dose that produces minimal side-effects is recommended (BAP, 2009).

For monitoring and evaluation refer to Lithium Guidelines. [Link to Lithium Guideline.](#)

If lithium is ineffective or poorly tolerated, there are a number of options. Switching to an alternative monotherapy or adding a second prophylactic agent should be considered (NICE, 2006).

Carbamazepine is regarded as somewhat less effective than lithium (Maudsley, 2009). It may sometimes be used as monotherapy, especially in patients who do not show the classical pattern of episodic euphoric mania (BAP, 2009). Drug interactions are a particular problem with carbamazepine.

The long-term efficacy of **valproate** is uncertain, although it probably protects against relapse both into depression and mania (Maudsley, 2009; BAP, 2009). SIGN (2005) states that there is insufficient evidence to recommend valproic acid salts as an alternative to lithium in maintenance treatment, though NICE (2006) recommends valproate as a first-line treatment. Valproate is not licensed for the prophylaxis of bipolar disorder.

Conventional antipsychotics have traditionally been used and are perceived to be effective although the evidence base is weak (Maudsley, 2009). There is evidence to support the efficacy of some **second-generation antipsychotics**. Whether they are more effective than typical antipsychotics and truly associated with a reduced overall side-effect burden remains untested (Maudsley, 2009).

Lamotrigine may be useful in bipolar II disorder (Maudsley, 2009) and prevents depressive more than manic relapse (BAP, 2009) (**unlicensed indication**). It should be considered if depression is the major burden of the illness and the risk of manic relapse is low (BAP, 2009).

For patients with bipolar II disorder with recurrent depression, lamotrigine alone should be considered for long-term treatment (NICE, 2006).

Lamotrigine is licensed for the prevention of depressive episodes in patients with **bipolar 1 disorder** who experience predominantly depressive episodes but has not been reviewed by the SMC at time of writing.

In an individual patient, a good response to any of these medicines during an acute episode of mania or depression may be considered as evidence in favour of its long-term use as monotherapy (BAP, 2009).

For patients with significant co morbid anxiety disorders, psychological treatment or a drug such as an atypical antipsychotic should be considered (NICE, 2006).

12.3 Combinations of drug treatments

Many patients experience sub-threshold symptoms or relapses on a single mood-stabiliser, so combinations of mood-stabilisers or a mood-stabiliser and an antipsychotic are commonly used (Maudsley, 2009; BAP, 2009). The prevention of relapse may often require complex treatment strategies (SIGN, 2005). There is some evidence that continuing combinations which were effective in mania provides optimal prophylaxis (Maudsley, 2009). **The risk of side-effects is increased when more than one drug is used. Combinations of two from lithium, olanzapine and valproate are recommended by NICE (2006).**

If the burden of illness is mania, it may be logical to combine predominantly anti-manic agents (e.g. lithium, valproate (unlicensed indication), an antipsychotic).

If the burden of illness is depressive, lamotrigine may be appropriate (only licensed for bipolar 1 disorder and not reviewed by SMC).

In bipolar I disorder, lamotrigine may usually require combination with an anti-manic long-term agent (BAP, 2009).

Patients should not routinely continue on antidepressant treatment long-term because there is no evidence that this reduces relapse rates, and it may be associated with increased risk of switching to mania (NICE, 2006) though antidepressants do appear to be used effectively in a small minority of patients in the long term (BAP, 2009). If the risk of severe depressive relapse is high, antidepressants to which patients have shown an acute treatment response may, appropriately, be continued long term (BAP, 2009). Long term monotherapy with (especially tricyclic) antidepressants is not advisable (SIGN, 2005).

Long-acting intramuscular injections of antipsychotics are not recommended for routine use in bipolar disorder. They may be considered for people who were treated successfully for mania with oral antipsychotics, but have had a relapse because of poor adherence (NICE, 2006).

Consider clozapine in treatment refractory patients. (Unlicensed use.) (BAP, 2009).

Rapid cycling

There is no basis yet for identifying rapid cycling as a particular sub-group requiring a different approach to treatment, though it does pose particular long-term management problems because of the associated illness intensity (BAP, 2009). Identify and treat conditions such as hypothyroidism or substance misuse that may contribute to cycling (BAP, 2009). Taper and stop antidepressants (BAP, 2009).

For many patients, combinations of medicines are required (BAP, 2009). NICE (2006) recommends a combination of lithium and valproate as first-line treatment, and lithium monotherapy as second-line. A combination of lamotrigine and either lithium or valproate may also be effective, especially in bipolar II disorder (NICE, 2006). Note licensed indications for individual medicines.

Evaluate anti-cycling effects over periods of 6 months or more (BAP, 2009).

12.4 Additional short term medication

The use of additional short-term medication (e.g. benzodiazepines or antipsychotics) is necessary when an acute stressor is imminent or present, early symptoms of relapse (especially insomnia) occur or anxiety becomes prominent.

Consider supplying short-term medications in advance to patients for use as required, though this option may not be suitable for every patient. Give clear advice about why, when and how to take additional short-term medication, and when to seek medical attention (BAP, 2009). Higher doses of the long-term treatments may also be effective if blood levels permit and the dose is below the maximum recommended dose (BAP, 2009).

12.5 Duration of treatment

The various guidelines differ in their recommendations about duration of long-term treatment.

According to NICE (2006), long-term drug treatment should normally continue for at least two years after an episode of bipolar disorder, and up to five years if the person has risk factors for relapse (a history of frequent relapses or severe psychotic episodes, co morbid substance misuse, ongoing stressful life events, or poor social support). This should be discussed with the patient and there should be regular reviews.

BAP (2009) recommends continuing treatment indefinitely: 'Patients who have accepted treatment for several years and have remained well should be strongly advised to continue indefinitely, because the risks of relapse remain high, even after years of sustained remission in patients who have stopped medication' (BAP, 2009). If stopping medication is to be attempted, patients should be helped to make an informed assessment of the potential risks and benefits (BAP, 2009). If the patient decides to stop medication, it should be phased out over a minimum of two weeks, and preferably longer. There is a high risk of early relapse into mania if lithium is stopped abruptly, making poor adherence a contraindication to lithium (BAP, 2009). Stopping medication should not be equated with withdrawal of services to patients (BAP, 2009).

13. Physical health monitoring

Physical health monitoring section of the Generic ICP guidelines will be followed and applied according to local arrangements and the care needs of the service user.

(Insert link to physical health guideline and shared care protocol– being developed.)

- **The care plan will evidence the process of regular physical health reviews** due to the high morbidity rates of people with this condition. The Physical Health Monitoring Record sheet should be completed for all patients and reviewed at least annually. This specific monitoring sheet will highlight the need to refer on to for example dietetics, physiotherapy or smoking cessation services for additional support and care in order to improve physical health outcomes

Physical Health Monitoring for People with Bipolar Disorder

Adapted from Maudsley Prescribing Guidelines 10th edition, including NICE Clinical Guidance 38: Bipolar disorder (July 2006)

	ALL patients		Medicine Specific Monitoring				
Test / Measurement	Initial check	Annual Check	Lithium	Valproate	Carbamazepine	Lamotrigine	Atypical Anti-psychotics
Thyroid function *	✓	✓	Refer to Guideline for the Management of Patients on Lithium (link)				Refer to Atypical Antipsychotic Monitoring Guidance (link)
Liver function	✓	✓		Baseline and at 6 months	Baseline and at 6 months		
Renal function (Urea and electrolytes, creatinine, eGFR)	✓	✓			Baseline and every 6 months		
Full blood count	✓	✓		Baseline and at 6 months	Baseline and at 6 months	Monitor if signs or symptoms of anaemia, bruising or infection	
Blood (plasma) glucose	✓	✓					
Lipid profile	✓	> 40yrs					
Blood Pressure	✓	✓					
Weight, waist measurement & BMI	✓	✓		Baseline and at 3 and 6 months	Baseline and at 6 months		
ECG	If indicated by history or clinical picture						
Plasma levels of drug (TDM)					Two weeks after initiation and two weeks after dose change. Then every 6 months		
Smoking/ alcohol	✓	✓					

* In rapid-cycling BAD, thyroid function should be checked every six months, plus thyroid antibody levels if indicated, for example by thyroid function tests.

Physical Health Monitoring Record Sheet

Patient's name:	CHI Number:	Consultant:
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Test / Measurement	MEDICINE(S):							
	Date	Result	Date	Result	Date	Result	Date	Result
Thyroid function	<i>e.g. GP</i> 12-12-10							
<i>signature</i>								
Liver function								
<i>signature</i>								
Renal function (U&Es, creatinine, eGFR)								
<i>signature</i>								
Full blood count								
<i>signature</i>								
Blood (plasma) glucose								
<i>signature</i>								
Lipid profile								
<i>signature</i>								
Blood Pressure								
<i>signature</i>								
Weight, waist measurement & BMI								
<i>signature</i>								
ECG								
<i>signature</i>								
TDM								
<i>signature</i>								
Smoking/ alcohol								
<i>signature</i>								
Comments								

14. Psychological Interventions

In recent years, there has been a shift from the sole management of bipolar disorder via pharmacotherapy to a combined hierarchical treatment model in which pharmacotherapy and psychosocial interventions both feature. Although there is an emerging evidence base regarding the effectiveness of psychological interventions for individuals with bipolar disorder, there is limited evidence regarding the superiority of any particular therapy: this may be due to the considerable overlap in the treatment modalities and treatment aims. Research has investigated the effectiveness of psychological interventions for reducing the severity of symptoms, increasing time to relapse, and for psychosocial factors such as improving quality of life. To date research evidence provides support for the use of psycho education, Interpersonal Social Rhythms Therapy, Behavioural Family Therapy, and Cognitive Behavioural Therapy for service users with a diagnosis of Bipolar Disorder. Information relating to these therapeutic approaches is summarised below.

[\(Please see appendix 3 for references.\)](#)

Psychological Therapy

Generic guidelines for suitability for psychological and/ or psychosocial interventions will be followed in accordance with the Generic ICP.

<ul style="list-style-type: none">• All service users presenting with Bipolar Disorder will be offered an assessment to establish their suitability for psychological therapy. This will occur within 18 weeks of the referral being received.
<ul style="list-style-type: none">• This assessment should be conducted by a clinical psychologist or other highly experienced psychological therapist/clinician who is skilled in working with this client group.
<ul style="list-style-type: none">• When deciding what therapeutic options, if any, are most suitable for the person, assessors will consider whether the person has received any previous psychological interventions, how they responded to this, the person's own preferences and choices about interventions, and the person's readiness and motivation for psychological work.
<ul style="list-style-type: none">• Intervention will be chosen in line with individualised formulations of the person's difficulties developed from the assessment by the clinical psychologist or other highly experienced therapist. . Even if a person does not wish to receive therapy or is considered unsuitable for it, a multidisciplinary team formulation will be developed in order to enable a shared understanding of the person's difficulties within the team and to inform the care plan. A clinical psychologist or other highly experienced therapist will lead this formulation.

14.1 Psycho education

The aim of psycho education is to provide theoretical and practical information to individuals (and significant others when appropriate) to help them understand and cope with the consequences of bipolar disorder, to improve medication adherence, to reduce suicide risk, and to improve social and occupational function. Psycho education is generally provided on an outpatient basis when the individual is no longer acutely unwell. It can be delivered on a one-to-one basis or in a group format.

14.2 Interpersonal Social Rhythms Therapy (IPSRT)

IPSRT is based on the theoretical assumption that life events can serve to disrupt social rhythms and circadian rhythms thereby making a patient with bipolar disorder vulnerable to a relapse. Within this therapeutic approach the patient is taught how to monitor and stabilise their sleep-wake cycle thereby stabilising irregular social rhythm (i.e. daily and nightly routines). Additional aims include helping the patient to identify triggers that are likely to disrupt normal social rhythms and to monitor their mood state. Psycho education and the resolution of interpersonal problems also feature in this approach.

14.3 Behavioural Family Therapy (BFT)

BFT is an evidence-based therapy working primarily with families where a member has a psychosis or other severe and enduring mental health problem. The aims of BFT are to reduce the risk of relapse and promote overall mental health; to assist all family members to achieve personal goals; to improve family stress management and problem solving skills; and to improve communication within the family. BFT is appropriate when the patient lives in a group or family setting or has very close family involvement. Further aspects that would indicate suitability for this approach include: a severe and enduring mental health problem (agreement about “diagnosis” is neither required, nor service user acceptance of any diagnostic label); and/or is at a maintenance or post acute phase of the illness. (The process of engaging the family can, however, usefully begin at a more acute phase.)

14.4 Cognitive Behavioural Therapy (CBT)

CBT focuses on helping individuals to develop skills to moderate their subjective experiences of real and perceived stressors. CBT for people with bipolar disorder can be delivered in a group format or on a one-to-one basis. Key components of this approach include: psycho education, life events scheduling for reducing over-stimulation, cognitive restructuring, problem solving, strategies for the early detection and management of prodromal symptoms, and learning how to challenge negative automatic thoughts and dysfunctional beliefs.

14.5 Individualising treatment: The need to formulate the patient’s difficulties

While there is an emerging evidence base for treatments such as CBT and IPSRT these approaches tend to focus on treating symptoms associated with the onset of episodes and consequences of episodes. It is helpful to use formulation to guide treatment options as patients can present with a co-morbid presentation, can have experienced trauma/complex trauma, may have attachment issues/relationship difficulties, and may have experienced/be experiencing a number of losses. Through the recognition of predisposing and precipitating factors, in addition to maintaining factors, treatment options that address the patient’s specific needs can be used. Therefore other therapeutic options such as Psychodynamic Therapy and Solution Focused Therapy may also be effective.

14.6 Self management

Key aims of self-management for chronic mental health conditions include involving the individual as an active partner in their illness management in order to improve their self-efficacy and self-esteem. Patient surveys in the United States and the United Kingdom show that individuals with chronic conditions desire both self-help and psychological treatments in addition to pharmacotherapy (Hill & Shepard, 1996; Lish *et al.*, 1994)²⁷. Self-management approaches can include prodromal monitoring, mood monitoring, attending self-help groups, and using CBT techniques and strategies.

Prodromal monitoring (which also features in the aforementioned therapies) is an example of a self-management approach that enables individuals to become actively involved in their illness management. The goal of prodromal monitoring is to reduce the likelihood of progression to a full-blown episode. Evidence shows that the detection and subsequent management of prodromal symptoms (defined as cognitive, behavioural, or affective symptoms that precede a manic or depressive episode) can assist in preventing an episode or reducing the severity of an episode. These symptoms can present during the interval between the time that symptoms are first recognised to the time when symptoms reach a maximum severity. The service user will have their own relapse signature and may benefit from working with a health care professional to identify relevant symptoms and to develop a management plan. This type of approach may not be suitable for all patients as it requires regular mood and behaviour monitoring.

In learning disabilities more reliance is placed on carers to detect prodromal symptoms with support from the learning disability teams.

Examples of commonly experienced prodromal symptoms are summarised in Table 1.

Table 1. Common manic and depressive prodromal symptoms experienced

Manic prodromal symptoms	Depressive prodromal symptoms
Reduced need for sleep	Interrupted sleep
More goal-directed behaviour	Low motivation
Increased sociability	Loss of interest in activities/people
Irritable/ Racing thoughts	Feeling sad or wanting to cry
Increased optimism	Difficulties getting out of bed
Over excitable/ restless	Feeling tired
Spending too much money	Difficulties putting worries aside
Increased self-esteem	Negative thinking
Loss of interest in food	Disinterest in food

15. Wellness and Recovery

The overarching principle is to enable mental well-being, facilitate self-management of symptoms and help reduce the impact of the illness on the quality of life.

In recent years mental health services have adopted the principles of a recovery model

According to the Scottish Executive report:

“Recovery is often described as a long-term process or 'journey' and is not simply the absence of symptoms. It is based on hope, involvement, participation, inclusion, meaning, purpose, control and self-management, and emphasises the importance of peer support, meaningful activity, employment, maintaining social networks and activities when distressed and having the chance to contribute, or give back, in some way.” (Scottish Executive (2006)

[Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland](#)

15.1 Medication Concordance

- The importance of taking medication should be discussed with the service user as failure to take medication as prescribed may influence the likelihood of relapse.
- Continue to offer regular opportunities to assess clinical presentation and review efficacy of current medication regime and discuss potential side-effects. Assist with medication management. **[Offer medication factsheets \(pharmacy\).](#)**²⁸
- Monitor and assess for any changes in psychiatric and physical co-morbidity.

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http://intranet.fv.scot.nhs.uk/home/Depts/PrimaryPharmacy/Pharm_Patient_factsheets/pharm_factsheets.asp

15.2 Health Maintenance and Education

- **Service users will be given the opportunity to learn about their illness either on a one-to-one basis or in a group environment.** Psycho-education can help service users understand symptoms and patterns of their illness thereby improving medication concordance and increasing time to relapse. Psycho-educational groups are the principle treatment offered in Resource Centres and provide patients with the opportunity to engage with other patients at different stages of recovery. This can be helpful in instilling hope, peer support and realising potential for self-management.
- **On-going monitoring of medication is vital at all stages of care and recovery and will be done in collaboration with the service user** by the identified service providing the care and treatment and will be noted in the service users person centred care plan according to person centred needs.

15.3 Lifestyle Management

- **Lifestyle factors will be addressed in a holistic way focussing on physical, social, occupational and emotional issues.** This can help the service user to cope with the consequences of bipolar disorder and to focus on factors which will improve quality of life. Mood diaries and activity scheduling are tools used to stabilise sleep-wake patterns, identify sources of stress and lifestyle behaviours. ([Please see appendix 4 –mood charts/diary](#))
- **Attendance at health and wellbeing groups held in community settings are also considered valuable in addressing psychosocial issues and optimising lifestyle management to stay well.** These groups can occur in voluntary and local authority sector settings and specific groups such as the Bipolar Scotland Support group link to post diagnostic support.
- **Referral to Occupational Therapy should be considered where it is evident that the patient has difficulty carrying out everyday activities** such as self-care, domestic, leisure or work activities. The overall aim of Occupational Therapy in keeping well is to improve the patients' functioning, ensure a balance between various occupations and to improve quality of life by meaningful engagement in his/her environment. In Forth Valley the Occupational Therapist will adopt the Model of Human Occupation to guide the use of assessments and interventions. This model compliments other therapeutic approaches and embraces recovery concepts.
- A variety of community resources are available in the Forth Valley area to support people to keep well. ([Link to SID.](#))²⁹ **(Work in progress to add information on bipolar disorder.)**
- **Wellness Recovery Action Plans (WRAP)**

This is a self-management tool currently available in all services. It should be used by a trained facilitator to help patients plan their care, reflect on coping strategies as well as aid communication between services involved. The tool should be completed in the stabilisation phase of the Bipolar Disorder and can be helpful thereafter in times of relapse. ([WWW.scottishrecovery.net](http://www.scottishrecovery.net))

The components of a WRAP include:

- what keeps people well.
- a daily maintenance plan.
- identification of triggers.
- identification of early warning signs.

²⁹ <http://www.sid.scot.nhs.uk/>

- identification of when things are breaking down.
- crisis planning.
- post crisis planning.

- **Advance Statements**

Under new mental health legislation service users are invited to complete an Advanced Statement which enables their treatment preferences to be documented should relapse impede decision making capacity in a crisis situation. This should be completed during the stabilisation phase of the illness. More information available at: <http://www.scotland.gov.uk/Publications/2004/10/20017/44081>

- **Outcome Measurement Tools** ([see appendix 1](#))

Bipolar disorder can be a lifelong relapsing condition and assessment tools should be an integral component of keeping well and recovery to ensure effectiveness of specific interventions and to identify when referral to other specialist services is required.

Outcome measurements can facilitate decision- making and best practice choices over time, from the perspective of the service user, their family, carers and other professionals.

What the results mean:

Indication & severity of depression

<http://www.qualitynet.org>

Name of Assessment: Geriatric Depression Scale**Abbreviation: GDS**

Staff member who can undertake assessment: Qualified staff with an understanding of clinical depression

Type of Assessment: Initial assessment of low mood in older adults

What the results mean: There are several versions of this assessment tool. The versions are governed by the number of questions to be answered. The most popular are the GDS 15, 10 and 4. The GDS 15 has the highest sensitivity rate (92.7%) whilst the GDS 10 and 4 both have higher specificity rates of 78.3%.

None of these tools is a substitute for a diagnostic interview by, mental health professionals but the GDS provides a useful tool for baseline measurements of mood and can facilitate the assessment of depression.

Reference site: www.medscape.com/viewarticle/447735

Reference site: www.ncbi.nlm.nih.gov/pubmed/10521885?dopt=Abstarct

Name of Assessment: Glasgow Depression Scale for People with a Learning Disability**Abbreviation: GDS-LD**

Staff member who can undertake assessment: Health professionals with an understanding of depression.

What the results mean: This is an assisted self completion scale by individuals with mild to moderate learning disabilities. It provides a useful tool for baseline measurements of mood and facilitates further assessment of depression. Therefore, it is not a diagnostic tool.

Cuthill F, Espie C, Cooper S-A (2003). Development and psychometric properties of the Glasgow Depression Scale for People with a Learning Disability. *British Journal of Psychiatry*, 182, 347-353

Name of Assessment: Carer Supplement to the Glasgow Depression Scale for People with a Learning Disability**Abbreviation: GDS-CS**

Staff member who can undertake assessment: Carers who can report their direct concerns and observations in a systematic way

What the results mean: This is for use in people with mild to moderate learning disabilities that provides a useful tool for baseline measurements of mood and facilitate further assessment of depression. Therefore, it is not a diagnostic tool.

Cuthill F, Espie C, Cooper S-A (2003). Development and psychometric properties of the Glasgow Depression Scale for People with a Learning Disability. *British Journal of Psychiatry*, 182, 347-353

Name of Assessment: The Psychiatric Assessment Schedules for Adults with Developmental Disabilities**Abbreviation : PAS-ADD**

Staff member who can undertake assessment: Qualified staff member who will require appropriate training to use this tool.

What the results mean: The PAS-ADD system has a primarily clinical emphasis, providing structured frameworks for assessment and case recognition. Threshold scores are provided for each of the above seven diagnostic areas. The instrument comprises 86 psychiatric symptoms and generates a series of sub scores on: depression, anxiety and phobias, mania, obsessive-compulsive disorder, psychosis, unspecified disorder (including dementia), and pervasive developmental disorder (autism). If the person reaches or exceeds a threshold, the implication is that they probably warrant a diagnosis. However, a strong emphasis is placed on clinical interpretation of the results.

<http://www.pasadd.co.uk/Mini%20PASADD.htm>

[Prosser H](#), [Moss S](#), [Costello H](#), [Simpson N](#), [Patel P](#), [Rowe S](#) (1998). Reliability and validity of the Mini PAS-ADD for assessing psychiatric disorders in adults with intellectual disability. [Journal of Intellectual Disability Research](#).42 (Pt 4):264-72.

16. 2. Appendix 2 – Bipolar Disorder Resource List

General Resources

A wide range of mental health information and resources are on the Moodjuice website. This includes information on crisis management. This site is accessible to service users.

Please click on link below to access this <http://www.moodjuice.scot.nhs.uk/index.html>

Specific Resources/ Websites

- **Royal College of Psychiatry website – Bipolar Disorder**
<http://www.rcpsych.ac.uk/mentalhealthinfo/problems/bipolardisorder/bipolardisorder.aspx>
- **Scottish Recovery Network**
The SRN's role is to act as a catalyst for change by sharing ideas and practice to promote recovery from long-term mental health problems, improving outcomes at all levels.
<http://www.scottishrecovery.net/>
- **Information site on Bipolar Disorder- mood diary**
<http://www.psychiatry24x7.com/homes/bipolar.jhtml>
- **Working Towards Wellness Toolkit**
<http://www.dbsalliance.org/site/PageServer?pagename=recoverysteps>
- **Lithium Knowledge Test /Lithium Attitudes Questionnaire**
<http://bjp.rcpsych.org/cgi/content/abstract/158/2/197>
- **The aims of Bipolar Scotland are:**
To provide information, support and advice for people affected by bipolar disorder/manic depression and all who care;
to promote Self-Help throughout Scotland;
to inform and educate about the illness and the organisation.
www.bipolarscotland.org.uk
- **Website – psycho education and support for service users**
<http://www.beatingbipolar.org/modules/flash/index.html>

16.3. Appendix 3 – References for Psychological Interventions (Section 14.)

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- Frank, E. (2007). Interpersonal and Social Rhythm Therapy: A means of improving depression and preventing relapse in bipolar disorder. *Journal of Clinical Psychology*, 63 (5), 463 – 473.
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Instructions for Completing a Mood Chart

What is a Mood chart?

A mood chart is intended to give you a picture of your mood over a period of time . It will let you see how it changes, and this can be related to other important information, such as changes in medication, problems with physical health or events that are happening in your life. This can show patterns that would otherwise be difficult to see.

The chart is yours to use as you wish, and you can record anything you want (or nothing at all!) in the comments section.

How to Complete a Mood Chart

Please write your name, the month and the year on each sheet.

The columns on the left are for recording your mood and the wide column on the right is for any comments you want to add.

To record your mood, shade the boxes that describe your mood at its best and worst that day. Thin diagonal lines are the quickest way to shade it in. It is best to record your mood at the end of every day, because it can be very hard to remember how you felt a few days ago.

If you did not feel depressed or elated all day, shade the box under 0.

If you were depressed at any time during the day, shade the box that shows the lowest you felt:

- | | | |
|----|---------------------|--|
| -3 | Severe depression | Could not feel worse. Cannot get anything done. |
| -2 | Moderate depression | More than a little low, but could be lower. Cannot get some things done. |
| -1 | Mild depression | Feeling low, but able to get things done |

If your mood was elevated at any time during the day, shade the box that shows the highest you felt:

- | | | |
|---|------------------|---|
| 1 | Mild elation | Feeling very good. Doing more or talking more than usual but this is not causing problems for you or other people |
| 2 | Moderate elation | Feeling on top of the world, or more easily annoyed than usual. Overtalkative, overactive or overspending to an extent that causes problems for you or others. |
| 3 | Severe elation | Feeling higher than high. Speaking so quickly that other people cannot follow you. Very overactive. Doing things that are out of character for you. Other people are worried about you. Definite problems for you or other people – but you may not be aware of this at the time. |

Mood Chart

Name: _____

Month: _____

Year: _____

Date	Depressed				Elevated			Comments
	-3	-2	-1	0	1	2	3	
1								
2								Started fluoxetine 20mg
3								
4								
5								
6								
7								
8								
9								Woke up feeling high for 2 hours. Low for the rest of the day.
10								In bed all day
11								
12								
13								Irritable
14								
15								
16								
17								
18								
19								Enjoyed trip to the coast
20								
21								
22								
23								Started new job
24								
25								
26								Drinking
27								
28								
29								
30								
31								

Mood Chart

Name: _____

Month: _____

Year: _____

Date	Depressed				Elevated			Comments
	-3	-2	-1	0	1	2	3	
1								
2								
3								
4								
5								
6								
7								
8								
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12								
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